MDR Tracking Number: M5-04-2669-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 3-27-03.

The IRO reviewed office visits w/manipulations, office visits, joint mobilization, therapeutic activities, myofascial release, neuromuscular re-education, hot/cold packs, electrical stimulation, DME, and ultrasound on 8-9-02 to 10-18-02.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO concluded that the office visits with manipulations, joint mobilization, myofascial release, therapeutic activities, neuromuscular re-education, hot/cold pack, and electrical stimulation were medically necessary from 8-9-02 through 9-13-02. The IRO agreed with the previous determination that the office visits w/manipulations, joint mobilization, myofascial release, therapeutic activities, neuromuscular re-education, and ultrasound were not medically necessary after 9-13-02. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services not addressed by the IRO and will be reviewed by the Medical Review Division. On 6-17-04, the Medical Review Division submitted a Notice to requestor to submit additional information necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

On 10-6-04 the requestor submitted an updated table. The updated table included three dates of service that were not on the original table and are disqualified from review – 7-22-02, 7-23-02, and 8-26-02. Also, per updated table, date of service 8-9-02 that was denied as unnecessary medical, was paid by the carrier and no longer in dispute.

The requestor billed $300.00 for code E0230 for date of service 7-24-02. This is a DOP code. Carrier paid $24.16 with denial code "F – the charge for this procedure exceeds the fee schedule or usual and customary as established by Ingenix". Per rule 133.307 (g)(3)(D), the requestor did not submit documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement. Therefore, no additional reimbursement is recommended.

Code E0745 billed for date of service 10-21-02 was denied as "A – preauthorization was required

but not requested." A review of the submitted EOBs indicates that code E0745 was also billed and paid on 7-24-02, billed again on 8-5-02 and denied as "A" and billed again on 9-16-02 and denied as "A". Per Rule 134.600 (h)(11), all DME in excess of $500.00 per item (either purchase or expected cumulative rental) requires preauthorization. Records submitted do not indicate that preauthorization was requested for date of service 10-21-02; therefore, no reimbursement recommended.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 9-9-02 through 9-13-02 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 9th day of November 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

Ph. 512/248-9020 **Fax 512/491-5145**
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 22, 2004

Re: IRO Case # M5-04-2669

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service 2/27/03 – 7/8/03
2. Explanation of benefits
3. Reviews 8/22/02, 11/4/02
4. D.C. treatment records
5. Report 2/4/03
6. TWCC-69 reports
7. ROM exam reports
8. D.C. comprehensive exam reports and re exam reports
9. TWCC work status reports
10. Prescriptions
11. Letter of medical necessity 9/16/02
12. Reports 8/6/02
13. Radiographic report of full spine 7/29/02
14. D.C. therapy notes

History
The patient injured his head, neck and low back in ___ when an A/C vent fell on his head and he had to grab a ladder to keep from falling, and he hurt his low back. X-rays and an MRI were obtained. The patient was treated with medication, physical therapy and chiropractic treatment.

Requested Service(s)
Office visits with manipulation, office visits, joint mobilization, therapeutic activities, myofascial release, neuromuscular re-education, hot/cold pack therapy, electrical stimulation, DME, ultrasound therapy 8/9/02 – 10/18/02

Decision
I disagree with the carrier's decision to deny the requested services through 9/13/02.
I agree with the decision to deny the requested services after 9/13/02.

Rationale
According to the records provided, the patient had an adequate trial of chiropractic treatment with good results. The documentation from the treating D.C. was adequate to support the necessity of the treatment for most of the dates in dispute. The D.C.'s records not only showed progression toward relief of the patient's symptoms, but also improved function. Range of motion examinations regularly showed improvement.
The patient received 30 treatments through 9/13/02 that appeared to be beneficial in relieving pain and improving function. Beyond 9/13/02 the patient's progress plateaued, showing no further improvement in pain relief or improved function. Thirty office visits was more than adequate, and based on the records, the patient appeared to be at maximum medical improvement as of 9/13/02. The patient's ongoing care after 9/13/02 did not appear from the records provided to be producing any measurable or objective improvement. The records do not contain any documentation of aggravations and/or exacerbations to explain the need for any ongoing treatment, and the records do not indicate how treatment was benefiting the patient.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____